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ABSTRACT

The course content of a laboratory session on patient interviewing taught to medical students taking a course on physical diagnosis is discussed in this paper. The first part of the paper describes the basic course content covered in the lectures: the bio-psycho-social model, the communication process, and the skills necessary for effective doctor-patient communication. The second part of the paper deals with the interview as a task-oriented process and provides an outline of communication activities for the patient interview. The remaining part of the paper offers an instructor's outline, student informational protocols, and patient programs (patients' medial problems, personal lives, social histories, and so forth) for a laboratory session designed to help physicians influence the behavior of patients after they leave the office. (HOD)

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TEACHING DOCTOR-PATIENT INTERVIEWING IN PHYSICAL DIAGNOSIS

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The Introduction to Physical Diagnosis at the University of South Florida College of Medicine begins the second semester of the first year and continues in the clinical setting throughout the second year. During the first year, students are introduced to concepts in physical diagnosis including the nature of disease processes and the importance of effective communication in diagnosis. During the second year they learn techniques of conducting the physical examination and work with real patients.

The directors of the physical diagnosis course are committed to the belief that knowledge of both the patient and the disease is essential to effective clinical practice. Hence, the course allows students to learn about both in tandem. Students meet 3 hours a week for 15 weeks. The first nine hours are devoted to lecture on the bio-psycho-social model, the communication process, and the skills necessary for effective doctor-patient communication. An additional 12 hours of class time are devoted to taking the sexual history, communicating across subcultural and ethnic differences, communicating with elderly patients, additional interviewing techniques, and small group interviews of actual patients. The classes on various body systems include demonstration interviews with patients suffering from problems with those systems.

In addition to the class lectures, all first year students participate in the patient interviewing laboratory. Students meet in groups of four. Each group meets for four, two hour sessions with an instructor holding a graduate degree in communication. The laboratory sessions feature discussion of concepts and skills to be taught in each session and practice of the skills by interviewing programmed patients. The laboratory sessions coordinate with the academic content of the lectures. In the laboratory students try out skills and discuss their effectiveness.

The particular session highlighted today is the fourth laboratory session. It is designed to help physicians influence the behavior of patients after they leave the office. Traditionally, these topics are referred to as patient education and patient compliance. We believe these terms are more physician centered and prefer not to use them. At the same time we do recognize the responsibility of the physician to take an active role in helping the patient learn about the illness and in helping the patient plan to implement the regimen the doctor and patient have chosen together. Clearly the physician's communicative behavior is instrumental to achieving these objectives.

Appendix 3 contains the detailed plan for session 4, along with the protocol giving the students information about the patient's problems. First year medical students do not have the specific clinical knowledge to deal with patients. We, therefore, give them this kind of description the week prior to each laboratory session. They then have that appropriate information when they begin the interview.

The appendix also contains the program given to the programmed patients which describes the patients' medical problems, personal lives, social histories, etc. Patients will reveal more or less of this information depending upon the skill of the interviewer. Individual programmed patients embellish their stories somewhat differently depending on the nature of the interview. Most programmed patients either adapt the program to their own life experiences or model their personas after people they know.

The process of instruction in each small group varies with the personalities and skills of the individual students. Care is taken to create a relaxed atmosphere and a climate of mutual support. With medical students whose entire effort to be admitted to medical school required a highly competitive orientation, there remains a competitive attitude. In order to foster cooperative and collaboration, students' course grades are affected only if they fail to attend. The skill of our communication instructors fosters the climate needed for active cooperation.

We also employ a technique we call a the "freeze" technique. The student interviewer or instructor can stop the interview and talk about what has been going on. The other students than act as consultants to critique the talk and make suggestions. We sometimes ask the programmed patient to comment from that persona's perspective. Different students may try different approaches and different techniques with a patient. We take considerable care to keep the atmosphere a positive one, to emphasize suggestions for doing things well and to avoid the kind of criticism that can engender defensiveness. The video tape will demonstrate what can happen in such class sessions.

At the conclusion of our first year of offering the interviewing laboratory experience, we obtained an open ended evaluation from our students. We asked them what we should keep and what we should change in the interviewing laboratory. Student comments were stunningly positive. Virtually no criticisms of the laboratory instruction were given. A few critical remarks asked for less reading of journal articles in preparation for laboratory sessions. The most frequent suggestion for improvement was to extend the length of the instruction period so that students could have even more practice. The structure of the course, the use of programmed patients, the participatory activity, and the quality of the instructors were all singled out by the students as items to keep. We are now in the process of a longitudinal study which we hope will tell us whether there is any change in record keeping and actual interviewing behavior of students who have participated in the laboratory.

BASIC COURSE CONTENT

COVERED IN THE LECTURES

COMMUNICATION IN PHYSICAL DIAGNOSIS

David H. Smith, Ph.D.

COMMUNICATION IN PHYSICAL DIAGNOSIS

INTRODUCTION. For most physicians, certainly for all physicians in primary care, the practice of medicine begins when the doctor meets the patient. Talking to the patient is the beginning of the process of diagnosis and treatment, and remains the heart of the practice of medicine for as long as the physician cares for the patient. With the array of scientific knowledge and technology available for physicians it is sometimes easy to forget that effective communication with patients is the most important tool in their care. Because their ability to talk effectively with patients and families determines much of their effectiveness as healers and their success as professionals, physicians can truly be said to be professional communicators.

Yet because communication is such an ordinary event - we talk all the time without thinking much about it - it is easy to overlook its importance. When we open our mouths, words come out. We assume that other people must understand what we have meant to say. We assume that what we hear them saying is what they mean. To do otherwise would be to doubt every comment in ordinary conversation. The time and effort required to exercise and to resolve such doubt would make the process of ongoing conversation and the interpersonal coordination of our lives nearly impossible.

Yet, we each experience enough misunderstanding, disagreement and communication failure to make us recognize that communication is not an automatic process. Just talking does not insure either that we have adequate information from others or that they will understand and agree with us. In Physical Diagnosis we will examine the communication process. Learning how it works can help make you confident in your talk with patients.

THE IMPORTANCE OF COMMUNICATION IN MEDICAL PRACTICE. Experienced internists will tell you that the effective interview with the patient is by far their most useful diagnostic tool. A portion of that interview is often called "taking the history". It is from information learned from the patient that the majority of diagnoses are made. This information also provides the basis for determining what tests to order to aid in the diagnosis.

One of the major problems facing physicians is what is often called the problem of patient compliance or cooperation. In a surprisingly high percentage of the cases patients fail to implement the treatment prescribed by their physicians. Clearly, from the physician's point of view, this is enormously frustrating. The physician's job is to heal. If the therapy prescribed is what heals, then the healing can hardly occur if the therapy isn't attempted. The doctor-patient interview provides the setting in which the physician can hope to influence the patient to implement the therapy prescribed.

Over and above its immediately apparent usefulness in diagnosis and prescription is the therapeutic effect of the conversation itself. People often feel better just from talking to a physician. Simply expressing concern may lead to reduction of anxiety and a consequent feeling of relief. Executing the social ritual of visiting the healer may allow a reconstruction of the patient's perceived reality, particularly if the healer has "laid hands" on the patient. One of the most powerful tools for healing available is reassurance. The doctor can tell the patient that the lump is not malignant, that the pain is indigestion not a myocardial infarction, or that

the feeling of fatigue is perfectly normal following a very stressful life experience. Being reassured by the physician's words will make the patient feel better. Knowing how to talk effectively with patients increases the power of physician reassurance.

Since becoming a medical student you may have been approached, even accosted, by a relative or friend who wants to tell you about an unhappy experience with a physician. This happens to many of us connected with medical education. One common theme appears in the stories we hear. That theme describes physicians treating patients or families as objects rather than persons. Those stories may tell of unreasonably long waiting periods, unreasonably short visits, the absence of an opportunity to ask questions, no explanation of information to the patient, failing to determine the patient's or the family's wishes, or an office staff that treats patients coldly or impersonally. The image of the impersonal, uncaring physician is at odds with what we know of the effective practice of medicine. When this depersonalized image is projected, however, it almost always comes from poor communication.

The opportunity to talk to the patient provides the opportunity to create just the opposite effect. The way you talk with your patients determines whether they are seen as ends or means only. Effective communication skills can allow you to determine what your patient's values are and to help the patient realize those values. Understanding how communication works and developing skill in using it will assist you in becoming the kind of physician you would most like to become. It will prevent you from being the subject of the kinds of stories mentioned above. It will make your patients satisfied with your care and likely to return to see you.

Communication, then, is an integral part of the effective practice of medicine. It is the most important tool in diagnosis and prescription, it is a therapeutic agent in and of itself, and it is the mechanism for implementing the most positive values we have for the practice of medicine.

COMMUNICATION AND THE GOAL OF THE COURSE. You are probably already a fairly competent communicator. Communication may not always work out well for you, but it works well enough, often enough, that you have been able to get through your life pretty well. You may remember important misunderstandings and disagreements, but they are likely to be the exception rather than the rule in your contacts with other people. Yet you may have only a superficial understanding of why you are competent, or of why you are effective in some situations and not in others.

Teachers of communication often say that people can be one of four things:

1. Consciously competent communicators
2. Unconsciously competent communicators
3. Unconsciously incompetent communicators
4. Consciously incompetent communicators

If you are consciously incompetent you at least know you have a problem and can work to improve. If you are unconsciously competent you are fortunate, but may not be able to adjust to new situations which require different competencies. If you are unconsciously incompetent there may be little hope for you. You have no idea that you are doing as badly as you are.

Our goal, of course, is for you to become a consciously competent communicator. We want you to understand why you do it well. To become a consciously competent communicator you will need to develop a positive attitude toward communicating, an understanding of how communication works and the skills necessary to implement the understanding you have developed. As the Physical Diagnosis course unfolds we hope to influence your attitudes, your understanding and your skills.

Some of what we will do will be designed to convince you that communicating well with patients is really as important as we say it is. As you proceed through your medical training you will be dazzled by the technology available for diagnosis and treatment. You will witness and be subject to the time pressures which make it easy to be terse with patients. You will encounter others in the process of medical education who will have so focused on a symptom, a disease, or a part of the patient, that they have forgotten that they are treating a total person, not a symptom, a disease or a body part. Throughout all this we hope you will remember that each patient is a person and that the way you talk with that patient is your primary means of recognizing personhood and its importance.

A number of studies show that medical students become less sensitive to patients as they go through medical school and residency. You may hear patients referred to as a "typical Tampa General clinic patient", a "dirt ball", an "old vet", or a "goner". You may even adopt some of that terminology yourself. You have learned that medical school is a time of considerable stress. The limits of your time and your energy will often be taxed. In midst of all that your attitude toward patients and the importance of talking effectively with them will be at stake. It may be easy for you to de-value your patients and to forget the important part of the motivation that made you want to become a physician in the first place. Only you can remain in control of your attitude toward communication and patients. Retaining your belief in their value as persons is a challenge well worth accepting.

UNDERSTANDING COMMUNICATION. Communication, its importance and effectiveness, has been studied at least as far back as the ancient Greeks. The study of communication has been an important part of learning throughout Western civilization. The concern of the ancients with rhetoric led to the trivium in medieval education. It has expanded to include an unprecedented emphasis on communication study in our contemporary communication-oriented society. The historical study of communication tells us that the nature of the society both reflects its communication system and determines the nature of the communication that will occur. What is true of a society as a whole is also true of the organizational and institutional subsystems within the society. Hence, the nature of the health care system determines the kind of communication that will occur, and that communication reflects the nature of the health care system.

First and foremost, communication has to do with the way people use symbols to create meaning. Communication deals with the symbolic, not the literal. It results in meaning. Further, the symbolic function is individual. To the extent that symbol systems are shared by those in a community or profession, the symbols become useful for communication. Yet the meaning given to symbols is always done individually, by individuals, and is often overlaid with individual emotion and personal experience. In science we attempt to develop symbols which have tightly prescribed meanings and which allow for no variability of meaning by individuals. This is done

to insure both careful thinking and precise communication. In the use of ordinary language, however, such precision is absent. In poetry and humor the ambiguity of language even creates joy. Ambiguity exists in non-verbal symbols, and the technical language (jargon) of any particular profession as well.

In addition to language and non-verbal symbols there are social symbols which influence meaning. Roles and the titles they carry influence meaning. Our understanding of the "proper" thing to do in a situation is symbolic. If an individual behaves "improperly" is "out of line" or "off base", meaning is constructed about the kind of person who would behave in such a counter-normative fashion.

Situations also carry symbolic weight. The acts that may be performed and the words that may be spoken differ from place to place. What is said in the barroom will be different from what is said in the classroom. The boudoir is not the examining room, nor is the bedroom the hospital room. An examination differs from a bull session. The meaning we assign to a particular act or comment varies from situation to situation.

Some symbolic acts have particular application for healing and for the practice of medicine. The white coat, the stethoscope, and the prescription pad may be utilized for reasons of occupational efficiency, but they become subjects to which special meaning is ascribed, both by those who use them and by those who see them.

Notice that in the comments above meaning has been depicted in the mind of the perceiver or the observer. The transportation metaphor is sometimes used for communication, but it tends to be misleading. No commodity or object is transported from one individual to another. The process of meaning creation goes on within the individual. The object, activity or situation becomes symbolic when an individual uses it in a symbolic way in the attempt to interpret what is going on. You cannot transfer meaning to another person such as a patient. You can, however, attempt to talk or behave in such a way that another individual is likely to ascribe to your talk and actions the meaning you would like to have ascribed. To the extent that you understand the conventional symbol systems such as language and ordinary non-verbal acts in the way the other understands them, you are more likely to make accurate predictions about the meaning created by the other, and to select the words or acts that will engender the meaning you desire.

People who share similar understanding of conventional symbols are more likely to be able to have similar meanings than those who do not. Hence, giving an explanation in medical jargon which a patient doesn't understand is not likely to leave the patient with the meaning you want. Using ordinary language the patient does understand is more likely to yield the desired result. Fortunately we do share a language and a linguistically derived conceptual system that makes it possible for us to talk. But in using conventional symbol systems, such as language, we need to take into account the individual characteristics and experiences of those with whom we are attempting to communicate.

Relationships between communicators also influence the way symbols are interpreted. Close friends, relatives, or lovers will communicate differently from strangers or those who are only professional colleagues. Conversation in close relationships tends to be less formal, and more direct. It leaves out words and phrases more often than does talk among people whose relationships are more formal and distant. Understanding the nature of the relationship in which you find yourself influences what you choose to say.

Because meaning is created by the individual hearing or observing and because it will reflect the experience and the internal state of that individual, we are constantly dealing with an imperfect and imprecise process. At best our communication attempts lead to understanding, to effective coordination of interpersonal activities, to agreement, to satisfaction, to joy, and even to love. Because of the imprecision of the process, however, some communication attempts lead to misunderstandings, to disagreements, and to frustrations. Simply talking in the presence of another does not insure a positive outcome. If we expect that another will understand us simply because we have spoken, we will find ourselves often disappointed and we may find it difficult to understand that disappointment. Often when a misunderstanding occurs, we blame each other for failing to understand. After all, our words were clear to us. Surely the other person's weakness created the difficulty. This blaming, of course, compounds the frustration and prevents any positive action to improve the communication. Understanding that communication attempts are fraught with possibility for different interpretations can free us to look for differences in meaning and to try to coordinate our understandings.

COMMUNICATION APPEARS TO INVOLVE RULES. Communication can be viewed, as can most other phenomena, from the perspective of structure and from the perspective of process. From the perspective of structure communication appears to proceed according to rules. Most of these rules are not taught directly; practically none is taught in school. Somewhere, however, each of us has learned the rules that go with ordinary conversation. We know that conversation involves turn-taking. We know that each successive turn in the conversation is appropriately related to the previous turn in the conversation. This is often done by a rule we call "topic tying". Our comment has some topical relationship to the previous comment of the other.

The form of the comment of the other also influences the form of the comment we use. In most cases a question is to be followed by an answer, a greeting by an acknowledgment or return greeting, a "thank you" by a "you're welcome", etc.

Additional rules seem to be related to the roles various participants are playing. When the other holds specialized knowledge, we will acquiese to the authority of that knowledge. When the other is child-like or is irresponsible, unable to look out for himself/herself, or out of control we are likely to be protective and solicitous. We will talk differently to an intimate than to a stranger. Somewhere without the benefit of a class in school we learned not to use dirty words in front of mother, and when it is appropriate to say "I love you". Viewed from a structure perspective all these appear to be rule-like regularities. We can analyze doctor-patient communication for these rules/regularities.

COMMUNICATION IS CONSTANTLY CHANGING. But, of course, communication may be also looked at from the viewpoint of process. When we do that, we see that communication is constantly changing, and that each new moment is created by the communicators in an on-going way. Conversations are thus spontaneous and creative. They exhibit unpredictability as well as regularity. Since each moment of talk is created anew in the moment when it occurs, each moment requires effort to make it as effective as possible. It also creates a new opportunity to achieve understanding and coordination that

may not have been achieved previously. A poor relationship may be reconstituted if the right words can be spoken as the moments of talk unfold, just as a good relationship can be damaged by the wrong words.

We can view the structural regularities of conversation as a series of constraints which limit the range of our creativity and our talk with each other. As long as we work within those constraints there are enormous possibilities to create positive outcomes with other people.

APPROACHES TO COMMUNICATION STUDY. Because of the importance of communication in our time, it has been examined by scientists, by technologists, by social scientists, and by humanists. It is not surprising, then, that there are a variety of ways of describing and analyzing the way communication works.

This situation is much like the situation in medicine. We have many theories of illness. We may say that people become ill because of the presence of micro-organisms, because of poor nutrition, because they lack appropriate exercise and activity, or because of high stress in their lives. They may become ill as a means of coping with psycho-social problems. They may become ill as a result of genetic predisposition or genetic defects, because of poor sanitation, or because of the presence of environmental pollutants or toxic substances in the workplace. Illness may be a manifestation of defects in the family system. A schizophrenic child or an alcoholic father may be a mechanism for maintaining balance within the family system. Some believe that illness reflects lack of faith. In less technologically centered societies, illness may represent a hex or the activity of evil spirits. It is probably fair to say that more people in the world believe that illness is a manifestation of spiritual problems than believe that it is based physiologically. You may be unwilling to accept some of these theories of illness, but as a medical student and a physician you will accept the usefulness of many of them.

The same theoretical situation holds in communication. We have a number of theories as to why communication works as it does. Each theory tends to bring with it a set of concepts and vocabulary. We will not ask you to learn about all the theories of communication, with all the concepts and terms, but there are four approaches to the study of communication which are particularly important for physician-patient communication. We will focus primarily on these.

FUNCTIONS OF COMMUNICATION. One way of applying those approaches is to talk about the functions that communication fulfills. These functions will overlap in any given conversation. At one time or another with one person or another or in one situation or another each of these functions may be more or less the focus of our conversational efforts. But each is an important aspect of our talk and each has special importance in doctor-patient communication.

RELATIONSHIP DEVELOPMENT. One function of our talk is to develop interpersonal relationships. We talk about "getting to know someone" through conversation. We say we want to find out "who someone is". We refer to some as "friends", "classmates", "strangers", "enemies", "lovers", "teammates", etc. Each term indicates some aspect of a relationship between two or more people. It is through our talk that these relationships develop. The nature of that talk determines who we are to each other.

People who understand one another well and have affection for each other can often converse in a direct manner. Sometimes their conversations seem almost insulting in their candor. Indeed teasing is an affectionate part of the talk in close relationships. Such communication between relative strangers would generate hostility. We know this so well that when we hear teasing, bantering and candor we usually conclude that the individuals have a close relationship. There are times when each of us has an intense conversation which has caused us to feel much closer to the other person.

Some communication theorists like to say that every conversation has both a content and a relationship dimension. They believe it is impossible to talk about something without talking about the relationship you have with the person with whom you are talking. Your selection of words, your tone of voice, your eye contact and other non-verbal behaviors, are often taken to be specially good indicators of the relationship. The formality of word choice is often another indicator. The use of first names, pronouns, and references to past experiences and similarity also carry indications of the nature of a relationship.

Much is made in the literature about the practice of medicine of the importance of the doctor-patient relationship. Understanding the relationship function of communication can help us understand the possibilities for doctor-patient relationships.

GIVING AND GETTING INFORMATION. Communication can also be viewed as having to do with information. Here the emphasis is clearly on content, what is said and what is heard. Some communication situations seem to involve the information function almost exclusively. Lectures in medical school or other educational settings, instructions to co-workers, the preparation of books or technical manuals, and the reading of reports or laboratory tests all involve the information function. Similarly, in conversation with others we may want to help them to find an address, to learn how to do a simple process or to know something we already know.

Clearly in the doctor-patient interview the giving and getting of information is important. The traditional view of the doctor-patient interview sometimes calls it "taking the history". The role of the physician is seen as getting information about the diagnosis from the patient and about treatment to the patient. In a certain sense information can be said to have been exchanged between the two.

The information perspective on communication rests on the work of engineers and scientists in electronics. There is a whole field of study based on what is called "information theory" that has to do with the conditions under which information can be transmitted with optimal efficiency. Such a theory has given us the words "message", "code", "noise", and through its extension into cybernetics has added "feedback" to our vocabulary. When we think of the doctor-patient interview we know that patients are unlikely to remember information if the code (language) used involves terms with which the patient is not familiar or if the patient describes symptoms using a subculturally useful term which the physician has never heard. When we talk about the doctor-patient interview it is useful to think about how the information function is being fulfilled.

PERSUADING. Another function of communication is persuasion. Often the talk we have with each other generates a change of belief or behavior on the part of one or both of the conversationalists. At times we engage in

conversation specifically for the purpose of persuading others. I may want to convince you to come with me to the gym rather than going home to study. I may want to you loan me your automobile or to agree with me about a political issue. Persuasion is the mechanisms used in the attempt to make that influence happen.

In describing persuasion we talk about "appeals" that are made for change in the belief or action of another. These appeals seem to work best when they fit already existing beliefs in the listener. If I want you to undertake an action, it helps if I can show you how this action fits your existing beliefs and values. Appeals which make sense, which seem to the listener to have good reasons, are likely to be more persuasive than those where the reasoning process seems faulty. Appeals also seem to work best when they involve some level of emotional intensity on the part of the persuader.

Some of the persuasive impact, however, seems to come from the character of the persuader, rather than just from the appeals. Who it is that does the persuading seems to matter. The word "credibility" is often used to describe this quality. We are more likely to be persuaded by appeals which come from persons we find credible. If the would-be persuader is lacking credibility, it is unlikely that we will be persuaded.

Credibility is often associated with the physician role, but it is also a characteristic which comes from the actions of individual physician communicators. The behavior of the persuader influences his/her credibility. Credibility is also related to the trust dimension of the relationship developed between two individuals. As we discuss physician patient communication we will stress the idea that the talk may be viewed as a setting for mutual persuasion in which each party is trying to influence the behavior of the other. The way they talk with one another becomes the most important method of implementing that influence.

RITUAL. A fourth function of communication is the execution of ritual. Much of what we say and do has significance beyond the mere meaning of the acts and words. Our most recognizable rituals are probably those associated with major events or forces in our social system. Religious ceremonies are obviously ritualistic. The specific words spoken at the graduation ceremony, marriage, christening, bar mitzvah or funeral are only a small part of the ritualistic significance of the entire ceremony. It is not the words of the Hippocratic Oath alone which are significant. The oath taking ceremony signifies tradition in medicine and healing. Connection with a centuries old ritual carries a special richness of meaning.

There is a ritual dimension to many seemingly ordinary events. Our greetings are clearly ritualistic. When we say "Hello, how are you?" we are not inquiring about the state of another person's health, but engaging in a ritual which dramatizes that we and the person greeted are in the same social group, have places in that group that are confirmed rather than challenged, and promise each other cooperation and friendship. Think what it means when two people are "not speaking to each other" and refuse to greet.

Rituals are particularly powerful in the reaffirmation or the changing of behavior. We often speak of rituals as either rituals of transition or of renewal. Families have routines which dramatize their solidarity. Lovers often have little rituals or ceremonies they enact together to reaffirm the constancy of their affection.

Much of the communication between doctor and patient may be seen as executing ritual. Clearly, faith healing, the casting out of devils or spirits, and purification rites in various cultures and subcultures add ritual to healing. But the visit to the doctor, the doctor's apparel and demeanor, the arrangement of specialized furniture and equipment, the use of special words, the laying on of hands, the writing of prescriptions, and the reassurance the physician provides may be viewed as a healing ritual. There is an aspect to the mere participation in the healing ritual which may itself heal. When we look at the communication which occurs in medicine as well as elsewhere we can be conscious of the extent to which it works successfully because it is a good ceremony.

Yet the ceremonial aspects may seem in conflict with the desire for informality and spontaneity just as they may seem in conflict with the desire to make the relationship personal. Enacting the doctor-patient ritual appropriately is an interesting challenge for physicians as well as for patients.

These general ideas about communication are discussed only sketchily above. By learning more about them you can develop a richer understanding of the way in which your communication takes place with everyone, friends, co-workers, classmates, subordinates, spouses, and lovers. This understanding will also equip you to analyze and improve the communication that goes on between you and your patient.

TALKING WITH PATIENTS

Effective communication with patients involves not only having a positive attitude toward communication and understanding the nature of communication, but also the mastery of skills that are specially important in the doctor-patient setting. Many of those skills are useful in other contexts as well. As you work in physical diagnosis class on mastering interviews skills you may want to practice some of them elsewhere. That practice will be helpful to you. Be aware, however, that your practice doesn't become so obvious that others feel you are using them.

INTERVIEWING TASKS. It is important in understanding the doctor-patient interview to see it as a task oriented process. You will often take pleasure in simply knowing the patient with whom you come in contact. You may find the conversation enjoyable, but there is a substantive reason why you and the patient have come together. The patient has come for help.

In accomplishing that goal you will need to accomplish a set of tasks. You will not attend to these tasks in any rigid sequence. Rather, your attention to each will come and go as the interview unfolds. If you attempt to force a rigid sequence on the interview, it is likely to be stilted, uncomfortable, and relatively unproductive. Don't try to force a rigid sequence; go with the flow of the interview. You may not attend to all of the tasks in any particular interview, but over the period of your contact with the patient, you are likely to find moments to attend to each. The tasks will vary in their importance each time you meet with the patient. You will want to consider which of these tasks are especially important for each meeting, and give thought to how more time and attention can be spent on the more important tasks. You should make sure to provide enough appropriate moments to accomplish those tasks you set out as the goals for a particular interview.

The interviewing tasks are as follows:

1. building a relationship with the patient.
2. learning about the patient.
3. learning about the patient's illness.
4. helping the patient with the emotional aspects of the illness.
5. helping the patient learn about health, illness, and health care options.
6. choosing an appropriate course of action with the patient.
7. helping the patient plan and carry out the chosen action.

COMMUNICATION ACTIVITIES. In carrying out the tasks of the interview you will engage in communication activities. Your tools will be communicative acts. The following activities will occur in most interviews. The activities, like the tasks, will not come in a particular order. You slip in and out of them as the interview unfolds. Some activities are specially relevant to some tasks, some to a number of tasks, and some tasks are served by a number of activities.

In the outline of activities below, you will find ideas and particular acts that fit each activity. Some are topics for talk, some are suggested comments, and some are specific acts or categories of acts. Make sure you understand each of these. Practice the communicative acts when you can in your everyday communication. We will use the activities in the laboratory exercises in this course.

I. Preparing for the interview

A. Using non-patient information sources:

1. Review the chart.
2. Talk to assistants, receptionists, etc.
3. Talk to other providers.
4. Talk to family members, employers, etc. where appropriate.

B. Consider which tasks are most important for the visit.

C. Consider factors which will facilitate or interfere with your conversation with the patient:

1. time availability.
2. place and setting.
3. likelihood of interruption.
4. your own state.

(a) fatigue
(b) mood
(c) health
(d) other pressure

D. Construct key questions you want to be sure to use.

II. Beginning the conversation

A. Words of introduction

1. Determine how to introduce yourself.
2. Use warm welcoming words.

B. Non-verbal communication

1. eye contact
2. voice-pitch, quality, and rate
3. handshake or touch
4. alert posture, focussed on the patient
5. alert, friendly facial expression

C. Put the patient at ease.

1. Assure the patient's physical comfort.

(a) dress
(b) temperature
(c) no light in the patient's eyes

2. Assure privacy.

(a) Close the door.
(b) Draw the drapes.
(c) Prevent or explain interruptions.

3. Arrange space to facilitate comfortable talk.

(a) Avoid barriers if possible.
(b) Respect the patient's personal space.

D. Make the relationship individual.

1. Make a little small talk.

(a) Talk about the patient's comfort.
(b) Talk about artifacts.
(c) Talk about the weather.
(d) Talk about the current events.

2. Talk about the person.

(a) "Where do you live?"
(b) "How long have you lived in Florida?"
(c) "I used to know someone by your name"
(d) "Are you still sailing, playing tennis, etc.?"

3. Give some items of information about yourself, such as where you're from.

E. Assess your response to the patient.

F. Assess the patient's expectation of the patient role.

1. dominating doctor and acquiescing patient.
2. guiding doctor and cooperating patient.
3. mutually participating doctor and patient.

III. Guiding the Interview

A. Using time effectively (providing appropriate moments).

B. Observing the patient and the process.

1. Observe physical diagnostic clues.
2. Note what the patient seems to want to talk about.
3. Note what the patient seems to want to avoid talking about.
4. Note what the patient hints at or mentions indirectly.
5. Assess the patient's:

(a) intelligence level.
(b) socioeconomic status.
(c) ethnic and cultural background.
(d) attitude.

6. Assess the patient's expectations.
7. Assess your feeling toward the patient.
8. Assess how the interview is going.

C. Influencing the behavior of the patient in the interview.

1. Creating an accepting climate for talk.

(a) Demonstrate understanding.
(b) Demonstrate empathy.
(c) Feedback the emotion the patient is displaying.

(d) Express respect for the patient.
(e) Offer reassurance to the patient.
    (1) "What you are experiencing is quite understandable".
    (2) "What you are feeling and thinking is very normal".
    (3) "What is happening to you is time limited".
(f) Encourage the expression of emotion.
(g) Build trust. (see below)
(h) Express support for, and partnership with the patient.
(i) Avoid climate destroying acts:
    (1) inappropriate probing.
    (2) evasion.
    (3) expressing judgment of the patient's behavior.
    (4) excessive reassurance.
    (5) hostility.

2. Getting the patient to tell you what you need to know.

(a) Use open-ended questions as much as possible.
(b) Feedback the content expressed by the patient:
    (1) The statement form is more effective than the question form.
    (2) Choose what to encourage in a complex response.
(c) Use encouragers.
(d) Use silence.
(e) Use orientation and transition.
(f) Ask for clarification.
(g) Use direct closed questions to get specific details.
(h) Use summaries.
(i) Use comments about the conversation (metacommunication).
(j) Be direct and brief where possible.
(k) Give feedback to the patient.
(l) Use a vocabulary which fits the patient.
(m) Avoid inhibiting techniques:
    (1) judgemental responses.
    (2) leading questions.
    (3) multiple questions.

3. Developing a trusting relationship with the patient.

(a) Create an accepting climate (see above).
(b) Use patient-oriented non-verbal behavior.
(c) Use appropriate self-disclosure:
    (1) about your own life.
    (2) about the communication here and now.
    (3) about your past relationship with the patient.
(d) Be descriptive, rather than evaluative.
(e) Be problem-oriented, not control oriented.
(f) Be spontaneous more than strategic.
(g) Be empathic, not neutral
(h) Be equality oriented, not superior.
(i) Give views provisionally, not dogmatically.
(j) Tell the truth.
(k) Keep your promises.

IV. Introducing topics to talk about in the interview.

A. The chief complaint

B. The present illness

1. Characterizing symptoms

(a) location
(b) quality
(c) severity
(d) timing
    (1) onset
    (2) duration
    (3) frequency
    (4) setting
(e) aggravating factors
(f) alleviating factors
(g) associated manifestations

2. Chronology

3. The meaning of the illness to the patient

(a) the reason the patient came to see you
(b) the reason the patient came today
(c) the patient's worries
    (1) the impact on the patient's family
    (2) the impact on the patient's work group
    (3) the impact on the patient's self image
(d) the emotions the illness triggered
    (1) fear
    (2) anxiety
    (3) anger
(e) The secondary gain the patient is receiving from the sick role
(f) the patient's diagnosis
(g) the patient's feared diagnosis
(h) the patient's fear of an illness a friend or relative has/had
(i) the image the patient has of the disease
(j) the patient's prescription

C. Past Medical History *

D. Personal and Social History *

E. Family History *

F. Review of Systems *

* See your textbook for detailed suggestions.

V. Influencing the patient's health beliefs and behavior

A. Teaching the patient

1. Find out what the patient already knows about the topic.
2. Use language appropriate to the patient.
3. Get the patient to participate in a dialogue rather than lecturing to the patient.
4. Use analogies, preferably those suggested by the patient.
5. Use only as much detail as the patient's seems to need and want.
6. Get feedback to check on the patient's understanding.
7. Ask the patient to demonstrate mastery of new behaviors.
8. Use diagrams, drawings, models, etc.
9. Reinforce instructions in writing where appropriate.
10. Check the patient's understanding at a subsequent visit and repeat the teaching where necessary.

B. Persuading the patient

1. Develop your own credibility with the patient.
   (a) Make comments that demonstrate your expertise.
   (b) Be dynamic and confident.
   (c) Build trust.
2. Reinforce positive patient behavior.
3. Involve the patient in making decisions as much as possible.
4. Make sure the patient really understands what the decision involves.
5. Attribute the choices to the patient.
6. Link the reasons for your recommendations to the patient's beliefs and values.
7. Help the patient develop a specific plan for implementing any behavior change.
8. Have the patient practice the new behavior or describe how it would work.
9. Ask the patient to promise to do what you and the patient have decided upon.

VI. Concluding the interview

A. Summarize what you have learned in the interview.

B. Ask the patient to affirm an understanding of your summary.

C. Review the treatment decision you and the patient have reached.

D. Ask the patient to affirm a commitment to implement the treatment decision.

E. Discuss any return visit.

F. Execute a friendly leave taking.

INTERVIEWING LABORATORY CONTENT

Interview Lab Sessions for Physical Diagnosis I

FOCUS	GOALS
	To give students opportunities to:
SESSION #1	
Task #1, Building the relationship.	Create a positive climate: --attend to the surroundings --greet patient courteously --use small talk and self-disclosure
Task #2, Learning about the person.	Assess initial responses: --responses to each other --patient's perception of roles and the relationship
Task #3, Learning about the patient's health and illness (initial information only).	Elicit the chief complaint(s): --develop introductory question --facilitate patient's completion of opening statement --uncover any secondary complaints or hidden agenda
SESSION #2	
Continuation of above tasks plus: Task #3, Learning about the patient's health and illness (complete).	Gather information using various types of questions, statements, and non-verbal behaviors to elicit: --information in the "traditional" categories --the meaning of the illness to the patient Adjust verbal and non-verbal behaviors to the individual patient and situation to enhance relationship development and information exchange
SESSION #3	
Continuation of the above tasks plus: Task #4, Helping the patient with the emotional aspects of the illness.	Increase interpersonal trust through: --appropriate self-disclosure --empathy, respect and congruence --Gibb's elements of supportive talk Facilitate expression of emotion as needed Offer support and reassurance

FOCUS	GOALS
SESSION #4	
Continuation of Tasks #1 - 4 plus:	Help the patient learn about the topic: --encourage a dialogue with the patient --minimize misunderstandings --aid retention
Task #5, Helping the patient learn about health, illness, and health care options.	
Task #6, Choosing an appropriate course of action with the patient.	Give information: --explanation --recommendation --instruction
Task #7, Helping the patient plan to carry out the chosen action.	Influence the patient's beliefs and behaviors: --by increased credibility --by use of specific communication tools

SESSION FOUR - INFLUENCING THE PATIENT'S HEALTH BELIEFS AND BEHAVIOR

A. Instructors Outline

B. Student Informational Protocols

C. Patient Programs

Instructor's Discussion Outline for Session #4

I. Introduction

A. Focus today on Tasks #5, 6 and 7

B. Discussion topics

1. How to help people learn (education "moments")
2. What information to give and how much
3. How to influence patient's beliefs and actions (persuasive "moments")

II. Exercise

A. Ask students to pretend that instructor is thinking of going to medical school, wants to know from them what medical school is like, why they chose this school, and how to go about applying.

B. After discussion, point out:

1. Giving information is not new to them.
2. Each person in group may choose different things to tell and recommend and approach the answers differently.
3. Similarities/differences in doctor-patient talk.

C. Post visual aids for Session #4, "WHAT" and "HOW" posters.

III. Lecture/Discussion re:

A. How to help the patient learn (no "bullet theory" of information transfer)

1. Encourage a dialogue with the patient

a. Find out what patient already knows.
(saves time and effort; additional reason for obtaining patient's diagnosis and prescription)

b. Find out patient's attitudes and beliefs.
(additional reason for learning "Meaning of the Illness")

c. Encourage expression of emotion for tension release as needed.
(recall therapeutic value of same discussed in last meeting)

2. To minimize misunderstandings and aid retention:

a. Use clear language. (KISS principle)

b. Use analogies and examples. (ex. of greasing a car's joints analogy used for patient who received cortisone shot for arthritis of knee.)

c. Use visual aids (drawings, models, diagrams, pamphlets) to enhance retention.

d. Reinforce in writing. (Put Rx for exercise on prescription pad, etc.)

e. Use communication tools they previously practiced including Clarification, Interpretation, Summaries with Feedback Request.

B. Information giving

1. How much to give.

a. What patients want (as much as possible)

b. Why doctors underestimate how much patients want

(1) Differing unexpressed expectations of doctor/patient
(2) "Diffidence strategy" of some less powerful patients
(3) Time factor

2. What to give.

a. Before decision is reached:

(1) Explanation
(2) Recommendation

b. After decision is reached:
(1) Instruction

C. How to influence

1. By your choices in what to talk about and how to talk about it.

2. By increasing your credibility (principle: "Increased credibility enhances the ability to influence"). Credibility factors:

a. Trustworthiness
b. Dynamism/Charisma
c. Expertise

3. During recommendation, by:
a. explaining your good reasons for the recommendation.
b. linking your good reasons to patient's beliefs and values.

4. By using the following communication tools:

a. Attribution of trait
b. Attribution of choice
c. Affirmation of intent

IV. Lecture/Discussion re ending the interview

A. Items to be covered via summary.

B. Concrete statement of next step in treatment.

C. Addressing patient by name again and use of touch.

V. Exercise. One programmed patient is used, as in Sessions #2 and 3.

VI. Instructor gives closing remarks and distributes Student Evaluation forms for students to complete before leaving concerning Interview Lab sessions.

Preparation for Interview Lab Session #4

In our previous meetings, our focus--on creating a positive climate, guiding the interview, and increasing interpersonal trust--was geared primarily to your getting information from the patient as you build the relationship and learn about the person and the problem. The focus of this final session is on your giving information to the patient and influencing the patient's beliefs and actions. You will continue to practice Tasks #1 through $4, but the emphasis this week will be on Tasks #5, "Helping the patient learn about his/her health, illness, and care options," #6, "Choosing an appropriate course of action with the patient," and #7, "Helping the patient plan how to carry out the chosen action."

To prepare for Session #4, please read the following:

1. Zisook, Sidney and Elizabeth Gammon, "Medical Noncompliance," International Journal of Psychiatry in Medicine, Vol. 10, #4, 1980-81, pp. 291-301.
2. "Influencing the patient's health beliefs and behavior," and "Concluding the Interview," p. 23 of the class handout, "Communication in Phsyical Diagnosis."
3. The attached Student Protocol.

Also, you will wish to familiarize yourself with the following procedural concepts and terms highlighted below for use in practice with the programmed patient.

A. How to help the patient learn about the topic

1. To encourage a dialogue with the patient:
   a. FIRST find out what the patient already knows about the topic.
   b. Find out the patient's attitudes and beliefs about the topic.
   c. Encourage expression of emotion as needed.
2. To minimize misunderstandings and aid retention:
   a. Use clear, concrete language.
   b. Use analogies and examples.
   c. Use visual aids (drawings, models, diagrams).
   d. Reinforce in writing.

B. What information to give

1. Before the decision concerning a course of action is reached:
   a. Explanation
      --about the topic
      --about the choices in the course of action
      --about any major side effects
   b. Recommendation
      --your expert opinion and the reasons for your opinion

2. After the decision is reached:

   a. Instruction
      --the specifics and details, such as how and when to take medications

C. How to influence.

You will be influencing the patient by your choices of what to talk about and how to talk about it. Also, increased credibility will enhance your ability to influence what the patient believes and does about the problem. Increased credibility or believeability is associated with:

1. Trustworthiness (the amount of interpersonal trust you and the patient have developed with each other)
2. Dynamism or Charisma (particularly as shown in your amount of interest in and concern for the individual and the problem)
3. Expertise (your special knowledge)

   To demonstrate your expertise, you may:

   a. Link yourself to the medical profession.

      Example: "Medical research has shown that . . . ."
      Example: "I think, and I believe that Dr. ____(with whom you're working) agrees, that the best way is . . . ."

   b. Refer to your own experience.

      Example: "I have found with my other patients that . . . ."
      Example: "Some doctors prefer this, but it's been my experience that (something else) works better."

   Also, while giving your expert opinion in recommendation, you will want to:

   a. Explain your good reasons for the recommendation.
   b. Link your good reasons to the patient's beliefs and values.

The following communication tools are particularly useful in accomplishing Tasks #6 and #7:

1. Attribution of trait, i.e., discovering and verbalizing to the patient a positive personality trait the patient possesses that you think can help the patient enact the course of action. Example: "You seem to be a very determined person; I think that determination will help you as you try to quit smoking."

2. Attribution of choice concerning the course of action, i.e., getting the patient to verbalize what "we" (you and the patient) or what the patient has decided to do, not, "Well, doctor, you want me to take these pills."

3. Affirmation of intent, i.e., after the decision is reached, getting the patient to tell you what the patient intends to do now about the problem (and why if appropriate).

STUDENT PROTOCOL: STOPPING SMOKING

As with losing weight, quitting smoking involves difficult life changes for a patient. As Mark Twain said about smoking, "Quitting is easy; I do it all the time." Your patient will have a physical condition that is brought on or aggravated by smoking. The patient already knows this. Your tasks for this talk are to help the patient learn about ways to quit smoking, and to help choose and plan a course of action.

The patient's two basic alternatives for quitting are either to enlist organized assistance, such as "Smoke-Enders," or to plan his/her own way to quit. Smoke-Enders costs $300 to $500 while the Seventh Day Adventist courses are usually free. Generally, in these classes films are shown and the smokers are given ways to help modify their behaviors. Studies indicate a one-year success rate for 20% to 50% of these smokers.

If the patient prefers to "go it alone," there are some concrete steps to quitting. One method is for the patient to note when and what s/he is doing when smoking, look for habitually associated activities, and then change those associated activities. For example, if the patient always has a cigarette with morning coffee, try substituting orange juice; if smoking occurs just after a meal, plan some substitute activity for just after eating. Another method is to mentally label each cigarette as a #1, #2 or #3. The #1's are the most-wanted cigarettes, the #3's are the least necessary cigarettes. Reduction in smoking occurs when the smoker first cuts out the #3's, then the #2's, and finally the #1's.

When reducing the number of cigarettes smoked, the patient can also carry gum, toothpicks, etc. to replace oral activity, brush teeth more often, and increase physical activities. Exercise is itself a good health measure, and it often makes the patient more keenly aware of any breathing problems. Also, the patient can plan frequent small rewards for him/herself, such as spending the unused cigarette money on some treat--a movie, book, etc.

A third, recently developed method for quitting uses Nicorette, a nicotine-laced chewing gum. Its manufacturer provides an instruction booklet that you may wish to review and discuss with your patient.

Stopping smoking requires both behavioral and attitudinal changes in the patient's life. You will want to find out about the support (or lack of it) the patient can expect from family members, friends, co-workers. Regardless of the patient's choice in alternatives to quitting, you will wish to emphasize and laud the patient for taking control of his/her life. Usually the first few weeks are the most difficult; emphasize the time-limited factor to this kind of suffering and the quickly-noticed benefits (increase in senses of taste, smell). Also offer your continued support and partnership with the patient in dealing with this life change. Since studies have shown that 90% of all recidivism occurs in the first three months of quitting, you may wish to plan frequent follow-up visits with the patient.

Student Protocol - Stress

Your patient has an illness which is exacerbated by stress.

Many illnesses are strongly affected by stress: the most common ones being "tension" or muscle contraction headaches, low back pain, irritable bowel syndrome with alternating diarrhea and constipation, and hyperventilation syndromes. It seems clear that many other "physical" illnesses can be exacerbated by stress including asthma, systemic lupus erythematosus, and coronary artery disease, to name only a few. It is often useful to discuss stress management with your patients.

The first task is to identify the major stressors. It is useful to approach this with an open mind; you will be surprised to find that some things which bother you do not bother others, and, conversely, your patient may be distressed about something you don't consider such a big deal. Common stressors are interpersonal relationship problems, work problems, economic problems, major life changes (loss of a loved one, moving, children being born or moving away). Explore this in an open-ended way, e.g. "Some people with your condition are made worse by problems or changes in their lives. Is anything going on in yours?"

You may then want to make some suggestions about stress management. Suggestions about how to solve the problem creating the stress tend usually not to work. People need to find their own solutions, though this certainly does not preclude your agreeing with a good solution. It is often helpful for people who have excessive stress to find a way to unwind. Particularly useful techniques include exercise, which can be anything from walking at a pace fast enough to cause mild breathlessness, to aerobic dancing, to jogging, to swimming. The most useful exercises for relaxation are the more rhythmic, sustained lower extremity activities, rather than something like racquetball, but generally you should support the patient doing what he/she enjoys to maximize compliance. Other techniques include yoga, deep breathing, meditation, biofeedback, self-hypnosis. These can generally be learned in a community course. They all work if used regularly. Obviously another solution is counselling or therapy, for people who have disfunctional coping styles. The key is to find the technique most compatible with the patient's personality and lifestyle and then prescribe it on a regular basis as a type of medicine.

Footnote: Many patients will respond "Exercise? I don't need any more exercise, I run all day." My response to that is that "running all day" makes you more pressured and tense, whereas regular time off to exercise truly relaxes you.

Explore your patient's lifestyle and preferences and try to arrive at a mutually agreeable form of stress management.

TENSION HEADACHES program

Patient uses extremes in vocabulary (esp. adjectives) such as if the person was constipated, she was "terribly constipated, in agony with it."

Description of headaches:

They start with a feeling, difficult to describe, in the shoulders, upper back area. "You can just tell" a headache is coming on. Then the feeling spreads up the back of the neck. The ache is worst in the nape of the neck. Sometimes it spreads up the back of the head and down to the eyes. It's a steady ache. No pounding. The headaches come on without warning.

If asked, light does not affect the ache. No vision disturbances. No flashing lights are seen.

There seems to be no pattern to the headaches. If asked, the headaches never wake the patient up when sleeping, and the patient never has them upon awakening.

Upon reflection and questioning, the pattern of the headaches is: the headaches come on on the weekend if there is stress at home; they come on during the week if there is stress at work.

Medications:

Patient has tried aspirin but it doesn't help much. In fact the patient becomes nauseated. (from the aspirin, really). The patient does have a loss of appetite with the headaches. The nausea causes the patient to describe the headache as "one of my sick headaches."

If desired, the patient saw a doctor in the past who said they were migraine headaches and prescribed Inderol one a day, but they didn't help.

PROGRAMMED PATIENT CASE HISTORY

The Person:

Name: Anita Summerhill Age: 38

Height: 5'3" Weight: 117 Blood Pressure: 110/72

Allergies: None Medications: Premarin 1.25

General Description: Good physical condition for her age

Chief Complaint: Insomnia

Details of present illness:

Location: All over

Quality: Restlessness, some difficulty in breathing at night; difficulty in falling asleep, wake up several times during the night; difficulty in concentrating; loss of appetite.

Severity: Insomnia for the last three to four weeks, now experiencing 2 to 3-hours of sleep per night.

Timing: Onset- 4 weeks ago

Duration: most of the night

Frequency: every night

Setting: at home and on the road

Aggravating factors: Possible coffee/tea intake; stressful job conditions

Ameliorating factors: Have tried over-the-counter medications, such as Sominex, Unicom, etc. to no avail

Associated manifestations: can't seem to keep eyes closed, or stop thinking

Chronology of present illness:

First occurrence: 4 weeks ago

Timeline: at this point, all night long

PAST MEDICAL HISTORY

Childhood illnesses: the usual measels, chicken pox, mumps; assorted colds and flus

Adult illnesses: suffered severe endometriosis for two years prior to total hysterectomy; occassional colds

Operations: Caesarian section, 1966

Injuries: none

Other: treated for mitral valve prolapse, 15 years ago

FAMILY HISTORY

Mother: Alive, age 65, housewife, never had a career outside the home

Father: Retired executive with a large, corporate firm, age 78

Sisters: None

Brothers: One, died during the outbreak of a polio epidemic, 1952

Spouse: Divorced

Children: One, a son now in college

PSYCHOSOCIAL HISTORY

Anita Summerhill is a self-employed interior decorator, currently in partnership with a (male) antique dealer, located in the Tampa Bay area.

Anita is still closely tied to her parents, a situation she wants out of, desparately. Her brief marriage ended in an early divorce, with one child. She moved in with her parents after the divorce, and together they raised her son. She has been trying to pull away from this emotionally stifling situation for the past three years. Because of her home situation, she has had no real relationship with a man since the disasterous one with her former husband.

After many years, she is finally becoming recognized in her profession. Her relationship with her current business partner is strained, as she realizes he is a practicing homosexual who dabbles in drugs, and, she suspects, might be importing cocaine along with antiques from out of the state and out of the country. The job gives her the financial independence to break away from her parents, but the illegality (suspected) makes her nervous.

Review of Systems (data pertinent to present illness)

Some constipation, occassional heart palpitations and loss of appetite.

MEANING OF THE ILLNESS TO THE PATIENT:

Reason for this visit: Wants sleeping pills for the insomnia

What is worrying the patient: Insomnia, business problems, personal problems

Impact of illness on:

1. Patient's family: short-tempered with mother and father

2. Patient's work group: difficulty in concentrating, short-tempered with business partner and suppliers

3. On patient's self-esteem: The once calm and composed professional businesswoman is now ill-prepared for work, loses concentration, and might be turning away needed business

Emotions generated by the illness: Have to face doctors, and face up to the need to take some action steps to pull away from the emotional relationship with her parents and the settlement of the problems in the workplace.

Topics to be avoided by the patient: Sex and releationships with men

Topics hinted at by the patient: Cocaine and its effects on people, illegal drugs and homosexuality

Patient's diagnosis: Insomnia

Patient's prescription: Sleeping pills

Anita Summerhill's history:

How do you feel about this illness: I'm worried about it. It interferes with my need for composure.

How have your relationships with your family members been affected by this problem? My parents always seem aware of my problems. If I'm not sleeping well and turn on my bedside light during the early morning hours, my mother always seems to know about it. My father will comment on my mood change.

My son is away at college, and is not really affected.

How have people reacted to you since you have had this problem?

My clients (hopefully) cannot tell I have not been sleeping well. My business partner is clearly aware of my short-temper and lack of concentration.

What do you do to get away from it all?

Take long, soaking bubble baths, increase my drinking.

Do you talk to anyone about your problems and about how you feel?

No, not really. Many of my "firends" are my clients, and I don't want to let them know that I'm not in top physical and mental consition.

What do you hope the doctor will do today?

Give me a prescription for sleeping pills.

Do you foresee any changes in your life?

One day, I hope to get an apartment all by myself.

How do you feel about your life?

I get a great deal of satisfaction out of the work I do. I am personally and financially rewarded for doing a good job, and I like that. My personal life is strained a bit, but I think that it's just a matter of time before I can resolve some of these conflicts.

How would you dress for a visit to the doctor? In loose-fitting clothes

How are you going to pay for the medical expenses? Personal check.

Describe a typical day in your life: Up at 6:00 a.m., breakfast, work out.

At work by 9:00 a.m. until 6:00 p.m. or later. I do bookwork and read trade magazines until bedtime. Occasionally I watch a little TV, or take in a movie or play (in season, my family has season tickets to several companies)

FOR: RON PUGLIESE

ADDITION TO PROGRAMMED PATIENT CASE HISTORY --
FOR USE IN SESSION #4, TO HELP PATIENT STOP SMOKING.

Several months ago, you were diagnosed by another physician as having angina. For these chest pains, you take what that doctor prescribed, that is, white nitroglycerin tablets that you put under your tongue when the chest pains begin. These tablets have been working well for you in that they control the pain. You take one whenever the pain occurs; lately, that's been two or three times a week. For the first few weeks, you noticed you'd get a headache after taking the nitroglycerin, but that seems to have stopped.

That doctor also wanted you to quit smoking cigarettes. You also had some symptoms of bronchitis--"smoker's cough", post-nasal drip, hoarseness. That doctor didn't tell you how to quit or make any suggestions, and you confess you weren't really ready to quit at that time. But now that your angina is under control, you're ready and need some advice. You want to quit for general health reasons and also to set a better role model for your students.

You've tried to quit by going "cold turkey"--no cigarettes at all--on two occasions, but it seems to have backfired and you find yourself smoking even more now--from 1 to 1½ packs a day up to 2 packs a day. When you tried to quit cold turkey, you were very irritable and nervous. Your wife insisted you come see a physician to learn about stopping smoking because you were driving her crazy when you tried to quit, and because you know there are a variety of methods to quit and want to have help medically in selecting the best way for you. Use your own background concerning how long you've smoked and the attitudes toward smoking of the people around you.

TRAINING PROGRAMMED PATIENTS

A. Instructions To Programmed Patients

B. Case History Form

INSTRUCTIONS TO PROGRAMMED PATIENTS

Please read your Programmed Patient's Case History information sheets. When first reading through the history, concentrate on the general statements concerning the patient's life, personality, and health. Then transpose this information to the blank case history form, adding details and feelings that you think this patient would have. Where possible, draw upon your own background to complete the details.

IN CLASS:

When you act as the programmed patient in class, each of the four medical students will be given an opportunity to talk with you while the instructor and other three students observe. During the conversation, the instructor will interrupt and ask you both to stop talking while elements of the conversation are discussed with the student interviewer and the other class members. Please attend to these discussions but refrain from commenting unless requested to do so. If you are asked to comment, please do so as you think the patient would. In other words, try to stay "in character" until the session ends.

When you are talking with the student, try to stay true to the general description of the patient. Try to react as you think the patient would under similar circumstances.

Feel free to ad-lib if the student raises questions about details that you have forgotten or that we have neglected to include. But try to make your answers and statements conform to the general outline we have provided.

Also feel free to ask the student any questions you think this patient would ask. You are probably safe in assuming that if you are having trouble with some point or other, this patient would also. If you think of any concerns this patient would have concerning the disease, its effect, treatment, etc., ask questions about them.

BEFORE CLASS:

When you receive an assignment to act as the programmed patient on a certain date and session, check to see for which session (number 1, 2, 3 or 4) you will be acting so that you will be prepared for the focus and goals of that session. (See your hand-out concerning Focus and Goals of each session.) For example, if you are assigned to a Session 1, where the focus is primarily on greeting and putting the patient at ease, you will probably not give much of the information with which you have been programmed, other than your initial statements concerning why you came to see the doctor. If, however, you are assigned to a Session 4 where the focus is on patient education and treatment decisions, you may anticipate your questions and concerns about kinds of treatment, their side effects, and how such treatment will affect your lifestyle. Since there will be some overlap of focus during each session (i.e., while giving information, there may be some moments when your patient will feel like expressing some emotions), it will be best to review your entire case history prior to class. But don't be dismayed if the students fails to elicit all the information in your program.

When you report for a class session, please check in with the departmental secretary for any instructions, and then take a seat in the hall outside the classroom, and please wait until we call you in. (Sounds like a "real" doctor's office, doesn't it?)

AFTER CLASS:

Please feel free to interact with the students as the session adjourns. Also, we will appreciate your comments concerning the session and would like to take a few moments after class to get your feedback.

If you have any questions or comments before or after you have attended a class session, please feel free to call us at 974-3294.

FOR: _____

PROGRAMMED PATIENT CASE HISTORY

Using the Case History we have given you, complete this form to "flesh out" your persona and to help you prepare for the sessions. This form is for your personal use. Begin by giving your persona a name.

Name: _____ Age: _____

Height: _____ Weight: _____ Blood Pressure: _____

Allergies: _____ Current Medications: _____

General description: _____

_____

REASON FOR THE VISIT: _____

Details of the Present Illness:

Location of pain/symptoms: _____

How does it feel? _____

How severe is it? _____

When do you get the feeling? _____

How long does it last? _____

How often do you get it? _____

Under what circumstances do you get it? _____

What makes it worse? _____

What makes it better? _____

What else comes along with it (such as fever)? _____

Chronology of Present Illness:

Describe the first occurrence of the symptom(s): _____

_____

Describe the second occurrence of it: _____

_____

Describe sequentially additional occurrences: _____

_____

Meaning of the Illness to the Patient:

Reason(s) you came to the doctor today: _____

_____

What is worrying you and why: _____

_____

Impact of this illness on:

1. Your family: _____

_____

2. Your work group: _____

3. Your self-image: _____

Emotions generated by the illness: _____

Your goal for this visit: _____

Your diagnosis of the problem: _____

Your prescription: _____

Past Medical History:

Childhood Illnesses: _____

Adult Illnesses: _____

Operations/Injuries: _____

Other: _____

Family's Medical History:

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Children: _____

Other relative: _____

Psychosocial History:

_____

_____

_____

_____

Fill in your history. Keep in mind the situation of your case, current medical problems and the background you have been given. Answer these questions as if you are the patient.

How do you feel about this illness ? _____

_____

_____

How have your relationships with your family members been affected by this problem? _____

_____

_____

How have people reacted to you since you have had this problem?_____

_____

_____

What do you do for fun or to get away from it all?_____

_____

_____

Do you talk to anyone about your problems and about how you feel? _____

_____

_____

What do you hope the doctor will do today?_____

_____

Do you foresee any changes in your life? _____

_____

How do you feel about your life?_____

_____

_____

How would you dress for a visit to the doctor?_____

_____

How are you going to pay for the medical expenses?_____

_____

Describe a typical day in your life.